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ABSTRACT

This paper focuses on the complexities of health care in Coober Pedy (South Australia) and the nearby Umoona Aboriginal community, and highlights the vital role of Aboriginal health workers in the implementation of primary health care principles. The Aboriginal population in this "outback" area is characterized by considerable economic problems, poor housing conditions, high unemployment and relatively few people in further education, low educational attainment, and an underlying reluctance to be counted in the census or to tell authorities of their current circumstances. Recent cause-of-death information shows a high incidence of heart and cerebrovascular disease, chronic liver disease often related to alcohol abuse, and injuries from violence including homicide and suicide. Hospital admissions are considerably higher for Aboriginal compared to non-Aboriginal persons, particularly for mental disorders, skin-related problems, and infectious and parasitic diseases. The Aboriginal Health Council of South Australia, Inc., an Aboriginal-controlled organization responsible for health policy, research, and community health coordination, has for many years stationed four Aboriginal health workers in Coober Pedy. The health workers provide health screenings, immunizations, and advice on health problems; hold family discussion sessions on such topics as financial problems, domestic violence, and alcohol-related problems; make referrals to the hospital; conduct health promotion and prevention programs; and serve as liaisons with community agencies and the schools. A recent child health workshop highlighted the lack of education and empowerment in the Aboriginal community. Increased collaboration between government agencies and Aboriginal health organizations is called for. (SV)

ED 390 599

ENOUGH BAD NEWS!

REMOTE SOCIAL HEALTH & ABORIGINAL ACTION IN A HARSH ENVIRONMENT — COOBER PEDY IN SOUTH AUSTRALIA'S 'OUTBACK'

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'The indigenous peoples of Australia are the poorest, sickest, most ill-educated, most chronically unemployed, most arrested and imprisoned people in this country' (Dodson 1993:119) - Social Justice Commissioner of ATSIC.

But the story must not end there'.

INTRODUCTION

The National Aboriginal Health Strategy, the Royal Commission Into Aboriginal Deaths in Custody, and the SA Aboriginal Health Chartbook all identify Aboriginal ill-health and reduced life expectancy as a continuing embarrassment to Australia's international reputation and so-called healthy national public policy. This paper responds to questions raised by the Umoona Community Council Substance Abuse Committee of June 1992 concerning (a) the role of alcohol, or heart or respiratory related problems in Coober Pedy Aboriginal deaths, (b) what is the relevance of 'environmental' or 'domestic violence' related issues to reported deaths?, and (c) how records kept by Aboriginal agencies compare with those of the South Australian Health Commission and the Australian Bureau of Statistics. We will return to these (empirical) questions later. A 5-year plan for the Umoona Community Council was prepared in 1990. It is currently under review - so one purpose of this discussion paper has also been to assist Umoona Community Council with that review.

Recent SA mortality data showed that Aboriginal death rates in the country were nearly 4 times that of their Adelaide city equivalents (that is, that in the country they were 18 times their non-Aboriginal equivalent compared with 'just' 4.6 times in the city of Adelaide) (SAHC 1993:89). Yes, this is startling, even given the normal 'colour' of Aboriginal health statistics, and we will return to other 'facts and figures' later, but before we do, we want to look at things a little differently.

From 'Four Corners' on our National TV network, to glossy coverage in 'women's magazines', Aboriginal health is renowned for its grim and graphic video footage - a continuous cliche of Aboriginal 'reality' that stands on par with that of Mozambique, or Somalia, or wherever poverty or misery attracts a news-hungry world, at least for a moment. 'Aboriginal health' is typically portrayed symbolically but not through traditional Aboriginal myth or spirituality - rather, through statistics, graphs, and charts. If we are serious about something, it 'must' be quantified . . . using scientific, valid and trustworthy 'facts'.

Two assumptions permeate this paper: firstly, that the grim realities of Aboriginal health cannot be denied, but that no statistical presentation can ever represent the complexities of Aboriginal social life and the diversity of Aboriginal communities. Secondly, that careful analysis of the underlying issues rather than merely the surface quantifications (and just as importantly, the local/regional definition of, and capacity to act on the underlying issues) still remains a rarity rather than a rule. There is a place for statistics, but we too often do not question their origins, meanings or scope. Therefore, what we don't need when we're talking about 'Aboriginal health' is either, more 'bad news' presented in isolation, or, superficial a-historical accounts of 'the problem' and 'the solution' – as if the 'remedy' is always straight-forward, applies everywhere, and is only held back by a lack of resources or an inept government. The reality, or rather, realities, are not straight-forward, and the role of *government* (in its many guises) as a key 'actor' in the 'Aboriginal health saga' is rarely considered closely. Rather, there is a continual focus upon Aboriginal 'behaviour' or

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'deprivation' or 'problems'. Governments provide services, training, personnel, infrastructure, people that analyse samples and count heads, people that hand over cheques, people who police health legislation, write guidelines for grant funds, and provide policies and legislation which uphold its principles and attitudes. Governments also have cultures, and histories of ways of thinking about *Aboriginality* which is all vital to this discussion. It would still seem to be the norm for Aboriginal people to be cast in the print and electronic media as *passive victims* in the saga of 'Aboriginal health' - not as agents of advocacy and change and certainly not as partners with government in tackling the myriad tasks ahead.

In South Australia, the Aboriginal Health Council took the initiative to develop an Aboriginal health policy in conjunction with Aboriginal agencies, Aboriginal-controlled health services, *and* with the cooperation of the South Australian Health Commission which provides public health services. This has formed part of the Council's Strategic Plan, which has recently been published in draft form. One of its fundamental tenets (and therefore one that must precede any discussion of actual 'case-studies' such as Coober Pedy) is that colonialism has left a messy, bloody and multi-faceted legacy, for example, the removal of children from parents, the economic fragility of communities herded into existence and now reliant on government support due to the dispossession of land, the failure of successive governments to educate Aboriginal people adequately or to pass on managerial skills to community leaders. Hostility is often felt toward anything that smacks of political 'quick-fixism', unnecessary bureaucracy, or the aggressive or judgemental element of police forces (and the wider community from which they are drawn), which has contributed to one of the most intolerable imprisonment rates in the world.

We feel this introduction has been necessary in order to help shatter a prevailing myth that Aboriginal health is basically about 'facts' and 'remedies': medicine, 'hospitals' and 'doctors', and the 'need for this or that to be done 'for' Aboriginal people'. Even an 'environmental health focus' widely misses the mark if considered in isolation from historical (and very contemporary) matters.

This paper argues from a *social health* perspective, that is: the conviction that health is much more than the absence of disease and illness . . . derived from the Ottowa Charter, the National Aboriginal Health Strategy, and so on [WHO 1986; SAHC 1988].[1] It hopes to assist Aboriginal organisations and mainstream health providers to devise a healthy public health policy for Coober Pedy and similar, remote regions (see eg., UPK Report 1987; Hancock 1990). In particular, we canvas the apparent dimensions of the needs presented to Aboriginal Health Workers, together with what they tell us they are doing in response.

[SLIDE 1. MAP]

[SLIDE 2 A, 2B, 2C. TOWN AREA photographs]

Coober Pedy in 'outback' South Australia is home to many hundreds of Aboriginal people either living in the town centre area or nearby Umoona Aboriginal Community. Famous for its stunning opals and tourism, mysterious disappearances, and summer's searing heat which drives people to their underground homes, Coober Pedy has an extraordinary ethnic mix: even in tourist literature it has earned the title of 'a disconcerting town'.

Before we turn to data on health services however, population data presents our first (epistemological) challenge. The 1991 Census data for the District Council of Coober Pedy is immediately striking from an Aboriginal perspective, as 291 people were accounted for on that winter night of June 1991, while there are over 490 people registered in the town health clinic, and there are approximately 100 family names who are regarded as 'locals' by community leaders. As most families are known to be quite large, some with 15 people in one dwelling for example, this figure of 291 is regarded as a gross undercount. Nevertheless, using this 'statistic', the Census recorded that of those over 14 years, 30% were in the workforce, and 11% were registered as unemployed; 70% were at the same address 5 years ago. The latter suggests nearly 1-in-3 lived elsewhere, however only a small number of those were reportedly interstate. Movement between Aboriginal centres or communities in SA is therefore highlighted, which, as any Aboriginal person will tell you, is quite common for community and cultural reasons (see eg., Gale and Wundersitz 1982). Local knowledge confirms a steady traffic between Coober Pedy and Yalata in the States far West, as well as Oodnadatta, Port Augusta, Ceduna in SA, and Finke in the Northern Territory – which has implications not only for record keeping but for health care.

Of those aged 15 or older, 17% left school before the age of 15 and a further 11% did not go to school at all. In other words, 1-in-4 had at most, an education to age 14; while 90% were 'not qualified' and just 3% had qualifications (ie., undergraduate diplomas). Hence Commissioner Dodson's assumption referred to in our opening remarks concerning Aboriginal people being the 'most ill-educated' seems supported by these Coober Pedy figures. Just 10 people, 7 of whom were female, were recorded as attending TAFE for some form of further education at Census time.

On employment, just 18 persons over the age of 15 (11%) were employed full-time - one half of whom were teenagers. None were employers or self-employed. However, and this reminds us of the need to question statistics on Aboriginal issues, 70 people (41%) did not tick *any* boxes on this issue! The reason for this is most likely to lie in the kinds of issues sketched in our introduction such as the fear of government and the past mis-use of research to which many Aboriginal communities have become accustomed. Of the 129 people who replied concerning their annual incomes, 93% were under $20,000, with 67 under $8,000 - way below the 'poverty line'.

A total of 52 dwellings were accounted for in the Census, 13 of which *usually* housed 6 or more people despite having at most, 3 bedrooms. Six of the 52 (11%) were owned or being purchased, while of the 43 rented, 40 were state owned houses.

Seventy-five percent of the 85 females over 15 years of age were single, either never married, divorced or widowed – but the Census Community profiles could not tell us how many of these 62 women were care-givers of children . . . sole parenthood is particularly high amongst Aboriginal people.

[SLIDE 3A, 3B. HEALTH SERVICE FROM OUTSIDE SHOWING PROXIMITY TO HOSPITAL /staff] .

Despite the undercount problem then, we can reasonably safely propose many aspects of the demographic profile of this Aboriginal community, such as its considerable economic problems, crowded housing, the relatively few people in employment or further education, and an underlying reluctance on the part of many, to tell authorities of their current circumstances – probably for fear of losing what meagre resources they possess.

We turn now to various health-related data: firstly to deaths data from both, the ABS and Aboriginal Health Workers.

Recent 'Cause of Death' information for Coober Pedy [based on ABS records from 1986 to 1991] showing a high incidence of heart and cerebro-vascular disease, chronic liver disease apparently related to alcohol consumption, and injuries from violence including homicides and suicide, suggests a community under significant stress and facing considerable social difficulties (unpublished ABS data 1993). But the difference between ABS and Aboriginal Health Worker deaths data is marked partly by their respective counts of relevant deaths (that is, 24 versus the health workers' 39 during this period), which highlights the difficulty of defining 'Coober Pedy residents' for such purposes. As Health Worker 'cause of death' data was not derived from medical sources and was frequently accompanied by '?' marks, it has not been compared with the ABS data - but the differences are interesting.

[SLIDE 4. APPROACH TO UMOONA - A DISTANT PHOTO ONLY ILLUSTRATING THE GENERAL ENVIRONMENTAL CONDITIONS]

Health workers by and large understand the communities in which they live and work. They know almost everyone and they are constantly talking to their friends and relations and hearing what is going on. It is noteworthy that of the 39 deaths reported by them: 2 were due to drowning accidents (one reportedly related to an episode of 'heavy drinking' which took place in Port Augusta); 2 to other accidents including a pedestrian hit by a car; 1 to suicide;

and 2 to homicides (both stabbings reportedly related to domestic violence cases: one female and one male victim – both in their 20's). The suicide was also a male in his 20's. Also, of 12 for whom a 'stroke' was suspected, a supplementary cause was listed by health workers as 'chronic alcoholism/heavy drinker'. Clearly such results indicate the grave concern felt about trauma, especially in relation to 'domestic violence' and the overwhelming perception that alcohol is related to much illness and many deaths.

However, death data is notoriously ambiguous the closer one looks (Weeramanthri, D'Abbs, and Mathews 1994). ABS death records 1986-1991 for residents of Coober Pedy revealed the following [see SLIDE 5]

[SLIDE 5]

CAUSE OF DEATH 1986-1991 – ABS RECORDS

CATEGORY	No
ACCIDENTS	3
CEREBROVASCULAR DISEASE	2
CHRONIC LIVER DISEASE & CIRRHOSIS	5
DISEASES OF THE DIGESTIVE SYSTEM	1
HOMICIDE	1
ISCHAEMIC HEART DISEASE	4
NEOPLASMS	2
PERINATAL CONDITION	1
RESPIRATORY-RELATED	5
TOTAL	24

With 5 respiratory-related deaths (including 3 from PNEUMONIA and one from 'TB'), the concern felt by the Umoona Council over respiratory-related conditions is highlighted, but impossible to expand upon without further information, and the role of alcohol abuse and/or violence remains unclear from these figures. It is also important to note that 'Injury & Poisoning' related deaths are apparently not uncommon for Coober Pedy residents generally, as for the years 1990 to 1992 there were 8 such non-Aboriginal deaths compared with 2 for Aboriginal people. Of course such small numbers are statistically meaningless, and due to the disappearances of back-packers in mysterious or violent deaths, or the tragic accidents of tourists walking backwards with cameras in the opal fields, any comparisons are also fraught with difficulty. Clearly, violence is not limited to the Aboriginal community. Coober Pedy can be a dangerous place to live . . . whoever you are.

[SLIDE 6 - shot of mine shaft or warning sign]

We now turn to illness-related data based upon admissions to Coober Pedy hospital during the period 1988 – 1992. [SLIDE 7] presents the ratio of the number of times it is more likely for an Aboriginal person of the same age and sex, as distinct from a non-Aboriginal person, to be *hospitalised* for the same type of condition *in Coober Pedy (expressed as a standard admissions ratio)*. It is clear that for all of the major categories for which at least 10 Aboriginal people were admitted between 1988 and 1992, at least twice as many admissions of Aboriginal people took place (as non-Aboriginal admissions – after standardisation by age and sex) – and for all but 3 categories, there were more than 5 times as many admissions. But this is only the beginning, as 10 times as many admissions took place for 'MENTAL DISORDERS', nearly 15 times as many for SKIN-related problems; and over 16 times for INFECTIOUS AND PARASITIC DISEASES. Anecdotal evidence suggests that this is more often due to the cyclic re-admission of a small number of individuals rather than a large number of Aboriginal people being admitted – but this is yet to be examined.

This extraordinary degree of hospitalisation is far in excess of that previously published for the State as a whole, but accurately reflects the profile of SA country admissions data for Aboriginal people for 1990 in which 657 Aboriginal people out of every 1,000 were admitted to a hospital, compared with 278 per 1,000 for the total population (SAHC 1993:19).

SLIDE 7

Obviously in the country there are fewer GP's, clinics, community health centres, Aboriginal health services – fewer choices overall - which helps produce such results. In Coober Pedy there is also a pattern of referral to hospital by the Aboriginal Health Workers who often see clients in need of medical attention – for many reasons. It therefore *could* be a good thing (for Aboriginal health) to have such high admission figures for Coober Pedy – it might be that conditions are being treated earlier and better than ever before. Hence, although it is tempting to draw quick conclusions from such results, and it is especially easy to assume from an economic rationalist perspective that such a level of health care is a worry, only further analysis of many other hospitalisation-related matters will improve our understanding – [and this will form part of on-going research by the Council – using Coober Pedy as a case-study of remote health care outside of Aboriginal community control].

So we have begun to appreciate the dimension of the bio-medical ill-health problems and the utilisation of hospital-based health services in Coober Pedy, but this tells us little about health – and what is being done to promote health amongst the Aboriginal communities.

HEALTH WORKERS' WORK

The Aboriginal Health Council of South Australia Inc., an Aboriginal community-controlled organisation responsible for Aboriginal Health policy, research and community health coordination, has for many years stationed 4 Aboriginal Health Workers (AHW's) there. Aboriginal Health Workers have been described as the 'grass-roots operatives' or the 'hub and the backbone' of the Aboriginal Health system. The work of Health Workers is poorly understood by the health professions generally, and anecdotal evidence also suggests this is the case with regard to some Aboriginal communities. Their work helps us to appreciate that: (a) the grim picture is not the only one – much is being done 'on the ground', every day of every week, by Aboriginal people or organisations, for and with other Aboriginal people, to address the most serious presenting health needs, and, (b) much more *must* be done *outside of the health system itself* – both within government and Aboriginal communities, to address the short and long-term well-being of such communities.

The Council's new *Aboriginal Community Health Information System*, (a modified computer-based community health information system developed for South Australia's community health centres), allows Health Workers to describe many aspects of their work in some detail for the first time. The principal reasons for individual or family– client contact with health workers (who are located in air-conditioned huts nearby the Coober Pedy hospital) were as follows [PIE CHART - SLIDE 8]:

SLIDE 8

There were 1,832 attendances for 296 clients over the previous 7 months (from October 1993 until April this year) since this record keeping began.

This pie chart shows that 40% of all Aboriginal client attendances at the Coober Pedy health service were for health check-ups, screenings, immunisations, seeking advice or assistance in relation to health problems of relations, and so on, rather than for a particular medical problem. 'Social problems' of various kinds, from unemployment-to-housing to-'domestic violence' – were the principal reasons for further 11% of visits to the service. Interestingly, 'laceration/puncture wounds' were common, with 78 attendances for 44 people while (and this is probably related), 21 clients presented for 'domestic violence' issues over 33 attendances. Mental/psychological/behavioural problems accounted for a further 10% – the latter, principally for alcohol-related problems. Various skin problems (5%) and injuries & poisoning (6%) accounted for another 11%, leaving 30% for the other categories.

Looking closer at these results, SLIDE 9 shows the kinds of issues for which clients were most likely to *return* to health workers for more than one visit.

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SLIDE 9

'Antenatal Care' (over 5.5 visits per client on average) followed by heart-related problems and skin problems (both approximately 4.5 visits per client) followed closely by alcohol-related problems, diabetes Type 1 and Post Natal Care. It is clearly also significant that financial problems, domestic violence, and wounds together with appointment reminders feature in this list of issues for which people return the most times.

Overall, it would appear encouraging that assistance is being sought for these types of issues – many of which do not result in medical attention, rather more often the matters are discussed and health workers and clients learn from each other as the Aboriginal community works to address its own problems in its own way. As such discussions are often family ones (which is clear from the extra 1,000 attendances also recorded by Health Workers during the one-to-one sessions with those registered clients discussed above), the learning extends well beyond the more typical 1:1 client-contact model of Western health care. A further 405 attendances took place with persons not registered – which were mostly brief, one-off visits.

As client referrals are frequently made to hospital, it is important to realise that this particular Aboriginal Health service offers a complimentary *approach to that of* Western health care (with its bio-medical focus). The hospital is also visited by Health Workers.

In addition, from time to time, traditional Aboriginal health practitioners are utilised, either by transporting clients to the Nganampa Health Service in the AP lands in the far north-west of the State, or by bringing one in to Coober Pedy to treat them there. Health workers therefore liaise also between the client and the traditional health providers, as well as the hospital – thus illustrating their vital, but poorly appreciated, brokerage role.

But the work of these health workers is not confined to individualistic client care, as routinely, they keep in touch with wider Aboriginal community life for example, through attendance at *funerals*), and, they conduct PROGRAMS for groups of people, eg., for the following [SLIDE 10]:

SLIDE 10

- Aged care/health
- Asthma
- Child Health
- Diabetes & Hypertension
- Disability Assessm't needs
- Domestic Violence W/shop
- Drug & Alcohol Discussion/Substance Abuse
- Emotional Health- Self Esteem
- Headlice
- Health Promotion & Education
- Meals
- Physiotherapy/Sports
- School Health Check
- School health class
- Senior girls - Sexuality
- Sexuality - general group
- Sexuality : Self Esteem & Sexuality (school)
- Women's health

In addition, intersectoral collaboration involving these Health Workers by way of support or liaison with other agencies, related to the following [SLIDE 11]:

SLIDE 11

- AHC: Policy & Planning
- Anti Poverty / community development (FACS)
- CAFHS – Child Development & immunisation
- Chest Clinic X Ray
- Child Care Centre
- Child health / Child Protection panel
- Community Development: Future Planning
- Ears Nose & Throat specialist clinic
- Eye health – trachoma
- Eye Health / trachoma clinic
- Family Planning / cervical screening
- Family Well-being
- HIV AIDS Education: school Program Planning
- HIV/AIDS National conference
- Interpreter Language Course
- Meals on Wheels
- Paediatrician
- Respiratory health – TB Screening
  – Asthma
- Rural Advisory Committee tele-conference
- School Education
- Substance Abuse Committee
- Women's Health – Cervical Screening

So you can also see how critical Health Workers are to wide aspects of the implementation of primary health care or soci health philosophy, in the health system and beyond.

We interviewed the Co-ordinator of the AHW's (the only non Aboriginal of the team of 4 – a registered nurse who has worked i Coober Pedy for 17 years) – to invite her opinion about 'what ha made a difference?' After consulting the health workers, sh commented that family planning, cervical cancer screening, genera compliance with health worker suggestions, sores, and ey problems . . . all had improved. However, ear problems and ski sores remained a constant concern as did the effects of alcohol an other drugs on the health of Aboriginal people as a whole - especially on infants and even upon the unborn. They als commented on the reluctance of teenagers to seek health advice o attention. She felt hygiene-related concerns such as scabies an sores directly reflected poor quality housing, overcrowding, an other environmental health matters such as the cost of water, do health, and so on – and the need for further health educatio amongst the community – to which we will return later.

We asked these health workers how they felt they were managin the constant demand for health services and if they felt resource were adequate? 'Yes generally' came the reply - apart from the lac of basic office equipment (a fax and copier) - which necessitate frequent time-wasting trips to the hospital.

Their vision for the Aboriginal community of Coober Pedy is fo more jobs, more housing of a good quality, less violence an substance abuse, better coordination and cooperation between th Aboriginal community generally and the wider community, and a more united approach from within the Aboriginal communitie which could better motivate families to take responsibility for thei own health *as much they are able*.

Looking beyond the work of health workers, other services withi Coober Pedy currently operate in these fields which are als directly concerned with Aboriginal well-being [SLIDE 12]:

SLIDE 12

WIDER PROGRAMS OPERATING IN COOBER PEDY

AGED CARE
CDEP – EMPLOYMENT [UNDER DISCUSSION]
CHILD CARE
CRIME PREVENTION
FAMILY CARE
HOMEMAKERS PROGRAM
HOUSING
YOUTH PROGRAM

There is also a Coober Pedy Community Development Committee. It is surprising that programs are not currently operating in the fields of either *Substance Abuse or Domestic Violence* – ones that everyone knows can be inter-related and which are again a major source of concern in the town - although there has apparently been funding approval for Domestic Violence services.

A recent Child Health workshop highlighted the need for the Community to: [SLIDE 13]:

SLIDE 13

CHILD HEALTH WORKSHOP

- TAKE GREATER RESPONSIBILITY FOR CHILDREN'S CARE
- REGARD THEM AS THE FUTURE AND EXPRESS PRIDE IN THEM
- NOT EXPECT TOO MUCH OF AGENCIES OR HEALTH WORKERS, AND TO CONTROL ALCOHOL-RELATED PROBLEMS AMONGST ADULTS SO AS NOT TO NEGATIVELY AFFECT THE KIDS

. . . which again highlighted the problem of substance use in the region.

In addition, the workshop raised the lack of 'communication, consultation, and coordination' between services and parents/community leaders, and lack of self-esteem amongst parents was listed as a *source* of many problems leading to substance abuse and poor parenting. This in turn, was linked to lack of education, and the lack of *empowerment* in the Community. *Two pages of strategies were recommended to begin to deal with this including the need for reconciliation programs to promote Aboriginal/non-Aboriginal respect and understanding, recreational/drop-in facilities particularly for the youth and parents, and for training/skills-building in community decision-making and "making things happen"*

Similar workshops have been held on Aged Care and Youth Issues, which raised many matters of a similar kind – and which are being followed up at present by AHC Health Workers. The need for better resources and more staff for care of the elderly has been stressed in conversations with Health Workers.

In conclusion, Aboriginal health in Coober Pedy is only simplistically 'encapsulated' by data about illness, death, or even what programs are running where. It is a dynamic town and community, with much traffic to and from the Ceduna/Yalata communities, and even the Port Augusta region. Aboriginal leaders who have lived in the town for many years have said that *'they understand how whitefellas get disillusioned'* . . . it is a town with big problems, big environmental obstacles, and not so big resources.

The obvious source of employment in the town which is tourism is not at present being 'tapped' in any significant way by the Aboriginal community (for a host of reasons that require a separate project to explore), and financial difficulty is commonplace . . . We should also remember this is a town where just to have water in your household can cost up to $240 a month – that's nearly $3,000 a year! – and where isolation, lack of support and community infrastructure minimises the likelihood of continuity amongst professionals – which means some services are still very thin on the ground while others remain non-existent. Dogs are thought to continue to be a major problem despite attempts to deal with them by the Umoona Council. The *dust* is often a precipitating factor in respiratory conditions. *Hearing* problems are reported to be widespread but this is another area for which systematic research has seemingly never taken place. *Food* quality is often reported to be poor, with insufficient variety – and of course it too is quite expensive relative to other less remote locations. Local publicans profit handsomely from the over-indulgence of *alcohol* by some Aboriginal people which has prompted other shop-owners to suggest the 'solution' to the 'problem' of Aboriginal drinkers in the town centre is to 'take them back to Umoona' . . . thus indicating a racist element in the town.

It has not been possible in the time available to receive direct input to this discussion paper from members of the Umoona Aboriginal Community Inc. – who are considering this paper for their own purposes. Other matters would need to be canvassed in a comprehensive account of public health in this remote 'outback' region, such as the quality of care provided at the Coober Pedy Hospital, the hospitalisation of residents in Adelaide rather than in Coober Pedy (about which, data is being pursued at present), the relationship between traditional culture and health in the region, and an evaluation of other government services stationed there and the policies under which they operate. There is clearly much scope for further dialogue and action in the face of the considerable challenges this unique place presents.

We have seen evidence of some level of intersectoral collaboration in Coober Pedy but from the perspective of this organisation, what still seems to be lacking is action that can be clearly seen to be flowing from strong government commitment to Aboriginal health policy in the wake of the National Aboriginal Health Strategy (NAHSWP 1989). That is, there is no clear model of partnership and collaboration with Aboriginal organisations 'on the ground' – ones which are regarded as those in control of their people's well-being. Neither is there a vision for the reform of 'mainstream' service provision to Aboriginal people. These are precisely what the Council's own Strategic Plan and Aboriginal Health Policy aims to promote. This 'double-edged sword' approach assumes that responsibility must be taken on *both* 'sides' of this cultural arena – with the principal onus remaining with the State.

Two things have therefore been argued: firstly, that the daily activities of Aboriginal people and organisations chipping away at the monumental iceberg of disadvantage and oppression— in the wake of the failures of the colonial state to address their needs and recognise their right to self-determination over many generations – should command greater recognition and respect from other health professionals and the media alike – rather than the endless saga of the 'negatives' in isolation. Indeed, it is clear that considerable effort is exerted daily in very difficult social circumstances and work environments. Following this, Aboriginal organisations also should be given the right to make mistakes. . .

And secondly, that poor housing and unemployment in particular are *fundamentally unhealthy social realities* which greatly increase the likelihood of substance abuse and crime which further undermines a community's capacity to respond to its multiple needs. While alcohol-focussed services would appear to again be needed after having been shut down in the late 1980's, they must not be provided in isolation from jobs and adequate shelter.

A planned, consultative, and systematic approach is therefore vital to the future of this community, else the kinds of bio-medical profiles we have canvassed today will persist. Things have changed in the decade which has passed since *The Report of the Committee of Review of Aboriginal Health in South Australia* (Foley 1984). Aboriginal organisations are working for the good of their own people – but they are continually hampered by forces beyond their control, besides the harsh climate of the region.

With regard to services currently not being provided but for which monies have been allocated, it would seem we do not fully understand why for example, Coober Pedy remains bereft of adequate services for those afflicted by 'domestic violence' – which together with substance abuse related problems, appears to be having a major toll on the community including its health and welfare workers.

In terms of future research, there is a clear need to move well beyond the usual statistical overviews common in Aboriginal health accounts, to explore particular socio-cultural ethnographic perspectives, but the gate has shut on traditional anthropological methods which for decades managed to ignore consideration of the actions and policies of the state, and which have contributed to research becoming a dirty word in many Aboriginal communities because they ignored fundamental issues of justice. Only politically astute, ethnographic research can begin to unravel questions such as why available resources are not utilised (if indeed they are available), why so few people are doing further education courses, whether the treatment of hospitalised Aboriginal people is appropriate, or which services or programs run by health workers are meeting their goals. Such qualitative research is still remarkably absent in this vital policy arena in Australia.

Finally then, it must be asserted that much is going on in response to many needs in the Coober Pedy region – by Aboriginal people and for Aboriginal people in particular – but many important questions remain before an adequate regional healthy public policy can be constructed based upon maximum Aboriginal input. The Aboriginal Health Council, having taken the initiative to facilitate South Australia's draft Strategic Plan and Aboriginal Health Policy looks forward to constructive discussion over its recommendations

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(as it does also to evidence of commitment to it by mainstream services). It is hoped that research such as this, focussing on the complexities of health care in Coober Pedy, has contributed to this process – in particular by highlighting the danger of simple solutions to complex problems, and of failing to recognise the vital role of Aboriginal health workers in the implementation of primary health care principles.

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[1] *The SA Health Commission has been noted for its progressive Social Health Policy [SAHC 1988] which continues to guide the implementation of various primary health care approaches to health in our State.*